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INTRODUCTION

Excerpt From Conference Program

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We as a society and we as a profession cannot condone having a significant population without access to health care. The cardiology community, while taking just pride in accomplishments bringing new therapies and procedures to the patient, must also become involved in seeing that appropriate cardiovascular care is made available to all. This must be done within the limits of finite resources that require our becoming more efficient and lowering unit costs. We can concentrate resources, use nonphysician health professionals more appropriately and define the roles of the subspecialist vis-à-vis the generalist. Training of subspecialists should be related to thoughtful assessment of future needs rather than programmatic or other considerations. Additionally, we need to become involved in helping society design the infrastructure and health care reform needed to expand care for our currently underserved population while maintaining appropriate services for patients requiring tertiary care.

This conference will explore these concepts and recommend change where data are available and suggest the data needed to make other recommendations for change.

Task Force 1

Task Force 1 reviews the plight of the underserved in obtaining cardiovascular care. It explores the problems of various populations, ethnic minorities and socioeconomically disadvantaged rural and urban populations and recognizes the need for a variety of solutions but a commonality of determination to provide appropriate care to all.

This Task Force charges the academic health centers in urban areas to become involved in the solutions to the problems by developing integrated delivery systems extending to community health centers. This would help in educating medical students and house officers in primary care, including outpatient clinical cardiovascular and preventive services. It should make these trainees more sensitive to the needs of a diverse underserved population.

The Task Force points out the need for more ethnic minorities to be trained in cardiovascular medicine and sets the stage for appropriate use of nonphysician health professionals to expand the capabilities of physicians in these underserved areas.

Task Force 2

Task Force 2 reviews the implications for academic health centers in the changing environment of medical care. The Task Force stresses the need for the profession's input into any decisions regarding allocation of training positions and the requirement that quality be the driving force in certifying training programs.

The Task Force recognizes the excessive numbers of interventional cardiologists being trained and the need for more physicians trained in clinical and preventive cardiology. Cardiologists in academic health centers must continue to direct the training of physicians in these latter areas.

Although academic health centers are inherently more expensive in health care delivery, they need to be subsidized more appropriately for research, patient education and delivery of care to the underserved.

The ability of recently trained highly specialized cardiologists to take patients away from the academic health centers needs to be addressed, as there will not be enough patients in some medical centers to enable them to stay at the cutting edge of new developments.

Research from areas such as molecular biology to new device development must be appropriately supported in academic health centers. They can foster development of practice guidelines as they develop resource-intense new therapies.

Task Force 3

Task Force 3 explains the relationship between physicians, physician assistants and advanced practice nurses in an integrated health care system. These partnerships will be necessary for delivery of care as the number of trainees declines and the need for care delivery expands. Physician assistants and nurse practitioners, working with a physician, can enhance patient education in health maintenance, substitute for house officers, provide care in underserved areas and learn highly skilled tasks such as cardiac catheterization.

Task Force 4

Task Force 4 explains the relationship between generalist physicians (general internal medicine, pediatrics and family

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practice) and cardiovascular specialists. It questions the adequacy of training for generalist physicians in cardiovascular medicine and proposes that academic cardiology become more involved in developing and executing a curriculum in cardiovascular education for the generalists. If the training programs turn out fewer cardiologists and more generalists, we must be certain that generalists are properly equipped to deliver cardiovascular care, particularly in the areas of preventive and geriatric cardiology.

Task Force 5

Task Force 5 examines the data related to future needs for cardiovascular disease specialists and concludes that if the now underserved are to be brought into the mainstream of cardiac care, more pediatric cardiologists are needed, cardiovascular surgery is in appropriate equilibrium, and there is an overabundance of invasive cardiologists. The challenge is to decrease the training positions and at the same time preserve the highest quality programs. If we assume that there is going to be a national commission of some sort regulating training positions, we must continually challenge the premise on which the numbers are determined and try to project the effect of technical advances on future needs.

Task Force 6

Task Force 6 reviews the scope and demographics of the field of pediatric cardiology. This subspecialty shares many common interests with adult cardiology but differs importantly in demographics and work force considerations.

Since the subboard of pediatric cardiology was established in 1961, only 1,074 subspecialists have been certified. The majority practice in urban areas because of the requirement for a resource-intense environment and the need for exposure to a broad range of diagnostic problems to maintain expertise. Rural areas are covered by a network of outlying clinics, collaboration with pediatricians and adult cardiologists and transfer of newborns to diagnostic and treatment centers.

Congenital heart disease is diverse in type and in presentation from fetal life to young adulthood. Whereas only 1% to 3% of children have congenital or acquired heart disease, the impact is large because of the length of anticipated life and the great differences in outcome related to the success of treatment. The requirement to provide sophisticated, high technology care for rare and widely diverse forms of heart disease in a heavily indigent population provides many challenges for the maintenance of resources for appropriate care delivery, training of future pediatric cardiologists and other care deliverers and the scientific advancement of the field.